

CDC Diphtheria Worksheet

PATIENT INFORMATION	Date of Request ____/____/____ <small>Month Day Year</small>		Name (Last, First) ____										
	Birth Date ____/____/____ <small>Month Day Year</small>	Age ____ <small>Unk = 000</small>	Age Type 0 = 0-120 years 1 = 0-11 months 2 = 0-52 weeks 3 = 0-28 days 9 = Age unknown	Sex <input type="checkbox"/> M = Male <input type="checkbox"/> F = Female <input type="checkbox"/> U = Unknown	Pregnant? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Race <input type="checkbox"/> N = Native Amer./Alaskan Native <input type="checkbox"/> A = Asian/Pacific Islander <input type="checkbox"/> B = African American <input type="checkbox"/> W = White <input type="checkbox"/> O = Other <input type="checkbox"/> U = Unknown	Ethnicity <input type="checkbox"/> H = Hispanic <input type="checkbox"/> N = Not Hispanic <input type="checkbox"/> U = Unknown						
	Address (Street and No.) ____		County ____	State ____	Zip ____	Phone ____							
CLINICAL INFORMATION	Date Symptom Onset ____/____/____ <small>Month Day Year</small>		Date First Diagnosis ____/____/____ <small>Month Day Year</small>		Date Hospitalized ____/____/____ <small>Month Day Year</small>		History of Immunization Against Diphtheria Childhood Primary Series? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown Boosters as Adult? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown Date of Last Dose ____/____/____ <small>Month Day Year</small> OR <input type="checkbox"/> U = Unknown						
	Description of Clinical Picture _____ _____ _____							Outcome <input type="checkbox"/> N = Recovered, No Residue <input type="checkbox"/> R = Recovered, Residue <input type="checkbox"/> D = Died <input type="checkbox"/> U = Unknown					
	Enter Y = Yes, N = No, or U = Unknown in the Boxes Below Unless Otherwise Indicated <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Symptoms</td> <td style="width: 20%;">Signs</td> <td style="width: 60%;">Complications</td> </tr> <tr> <td> Fever? <input type="checkbox"/> Sore Throat? <input type="checkbox"/> Difficulty Swallowing? <input type="checkbox"/> Change in Voice? <input type="checkbox"/> Shortness of Breath? <input type="checkbox"/> Weakness? <input type="checkbox"/> Fatigue? <input type="checkbox"/> Other? <input type="checkbox"/> </td> <td> Fever? <input type="checkbox"/> If Yes, Temp _____ °C Membrane? <input type="checkbox"/> If Yes, Site(s) _____ Tonsils _____ Soft Palate _____ Hard Palate _____ Larynx _____ Nares _____ Nasopharynx _____ Conjunctiva _____ Skin _____ Soft Tissue Swelling? <input type="checkbox"/> Neck Edema? <input type="checkbox"/> If Yes, Extent _____ Stridor? <input type="checkbox"/> Wheezing? <input type="checkbox"/> Palatal Weakness? <input type="checkbox"/> Tachycardia? <input type="checkbox"/> EKG Abnormalities? <input type="checkbox"/> </td> <td> Complications? <input type="checkbox"/> Airway Obstruction? <input type="checkbox"/> Date of Onset ____/____/____ Intubation Required? <input type="checkbox"/> Myocarditis? <input type="checkbox"/> Date of Onset ____/____/____ (Poly)neuritis? <input type="checkbox"/> Date of Onset ____/____/____ Other? <input type="checkbox"/> Describe: _____ </td> </tr> </table>								Symptoms	Signs	Complications	Fever? <input type="checkbox"/> Sore Throat? <input type="checkbox"/> Difficulty Swallowing? <input type="checkbox"/> Change in Voice? <input type="checkbox"/> Shortness of Breath? <input type="checkbox"/> Weakness? <input type="checkbox"/> Fatigue? <input type="checkbox"/> Other? <input type="checkbox"/>	Fever? <input type="checkbox"/> If Yes, Temp _____ °C Membrane? <input type="checkbox"/> If Yes, Site(s) _____ Tonsils _____ Soft Palate _____ Hard Palate _____ Larynx _____ Nares _____ Nasopharynx _____ Conjunctiva _____ Skin _____ Soft Tissue Swelling? <input type="checkbox"/> Neck Edema? <input type="checkbox"/> If Yes, Extent _____ Stridor? <input type="checkbox"/> Wheezing? <input type="checkbox"/> Palatal Weakness? <input type="checkbox"/> Tachycardia? <input type="checkbox"/> EKG Abnormalities? <input type="checkbox"/>
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LABORATORY	Specimen for Diphtheria Culture Obtained? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown If Yes, Obtained on ____/____/____ OR <input type="checkbox"/> U = Unknown		Culture Result <input type="checkbox"/> P = Positive <input type="checkbox"/> N = Negative <input type="checkbox"/> U = Unknown Specify Lab Performing Culture: _____		If Culture Positive, Biotype <input type="checkbox"/> M = Mitis <input type="checkbox"/> G = Gravis <input type="checkbox"/> I = Intermedius <input type="checkbox"/> B = Belfanti								
	If Culture Positive, Results of Toxigenicity Testing <input type="checkbox"/> X = Not Done <input type="checkbox"/> P = Positive <input type="checkbox"/> N = Negative <input type="checkbox"/> U = Unknown	Specimen Sent to CDC Diphtheria Lab for Confirmation/Molecular Typing? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> W = Will be Sent	Type of Specimen (Check All That Apply) <input type="checkbox"/> Clinical Swab <input type="checkbox"/> Piece of Membrane <input type="checkbox"/> C. diphtheria Isolate	Serum Specimen for Diphtheria Antitoxin Antibodies Obtained? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> W = Will be Obtained Prior to DAT	PCR Result <input type="checkbox"/> P = Positive <input type="checkbox"/> N = Negative <input type="checkbox"/> U = Unknown <input type="checkbox"/> X = Not Done								
	As an Outpatient Treated with Antibiotics? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No If Yes, Date Initiated ____/____/____ Antibiotic <input type="checkbox"/> See Codes Below Duration of Therapy ____ Days		As an Inpatient Antibiotic Therapy in Hospital? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No If Yes, Date Initiated ____/____/____ Antibiotic <input type="checkbox"/> See Codes Below Duration of Therapy ____ Days										
Were Antibiotics Given in the 24 Hours Before Culture? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Antibiotic Codes 1 = Erythromycin (incl. Pediazole, Ilosone) 2 = Penicillin (Bicillin, Pfizerpen-AS, Wycillin) 3 = Amoxicillin/Ampicillin/Augmentin/Cefclor/Cefixime 4 = Clarithromycin/azithromycin 5 = Cotrimoxazole (bactrim/sepra) 6 = Tetracycline/Doxycycline 7 = Other 9 = Unknown											

Note: This Form Has 2 Sides

EXPOSURE	Country of Residence <input type="checkbox"/> U = US <input type="checkbox"/> O = Other		If Other, Country Name: _____		Date of US Arrival _____ OR _____ Month Day Year U = Unknown																															
	History of International Travel? (2 Weeks Prior to Onset) <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Country(s) Visited <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3">From</th> <th colspan="3">To</th> </tr> <tr> <th>Month</th> <th>Day</th> <th>Year</th> <th>Month</th> <th>Day</th> <th>Year</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				From			To			Month	Day	Year	Month	Day	Year																		
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Month	Day	Year	Month	Day	Year																															
Known Exposure to Diphtheria Case or Carrier? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Known Exposure to International Travelers? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Known Exposure to Immigrants? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown																																

REPORTING INFORMATION	Has This Suspected Case Been Reported to The State or Local Health Department? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Date Reported to State or Local Health Department _____ Month Day Year	
	Person Informed: _____		Phone: _____ Fax: _____	
	Reporting Physician: _____		Phone: _____ Fax: _____	

REPORTING PHYSICIAN	Name				
	Institution				
	Street				
	City			State	Zip
	Phone		Fax		
	Name of Investigator Under the IND (if Different From Requesting Physician)		Phone		Fax

SEND DRUG TO	Name				
	Attn.				
	Institution				
	Street				
	City			State	Zip
	Phone		Fax		

DOSE	Amount of DAT Administered: _____ IU DAT	

DISPOSITION	Final Diagnosis: _____	How Was the Final Diagnosis Confirmed? _____	Final Case Disposition <input type="checkbox"/> C = Confirmed <input type="checkbox"/> P = Probable <input type="checkbox"/> N = Not a Case

Information for Close Contacts* Diphtheria

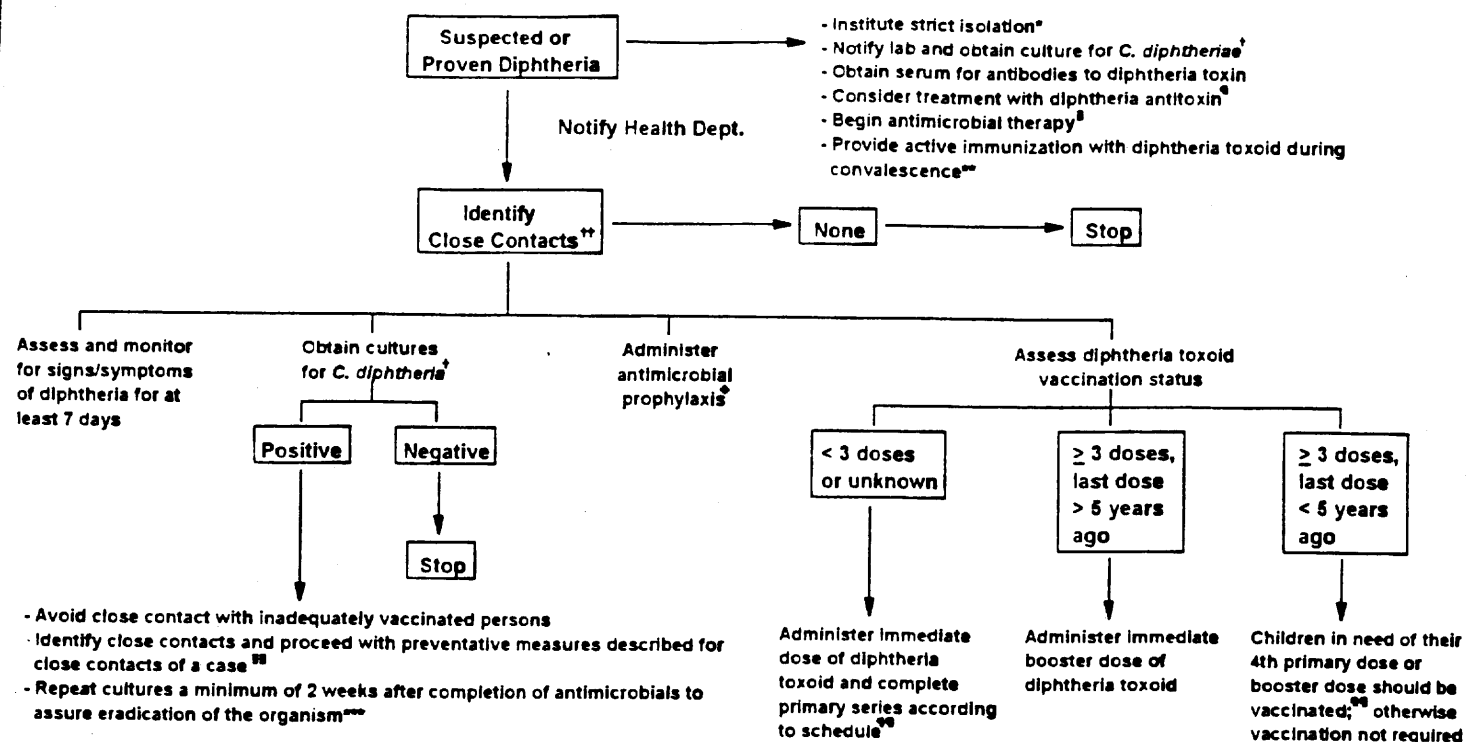
*Close Contact = Household members and others with a history of direct contact with a case-patient, and medical staff exposed to oral or respiratory secretions of a case-patient.

Name	Age	Relation to Case					
Vaccinated? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	If Vaccinated, Number of Lifetime Doses <input type="checkbox"/> U = Unknown <input type="checkbox"/> L = < 3 Doses <input type="checkbox"/> G = ≥ 3 Doses	If Vaccinated, Last Dose <input type="checkbox"/> L = ≤ 5 Years Ago <input type="checkbox"/> G = > 5 Years Ago	Nasopharyngeal Culture Obtained? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Oropharyngeal (Throat) Culture Obtained? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Date of Culture Month Day Year	Results <input type="checkbox"/> P = Positive <input type="checkbox"/> N = Negative <input type="checkbox"/> U = Unknown	Antibiotic Prophylaxis <input type="checkbox"/> See Codes Below
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Antibiotic Codes

- | | |
|--|-----------------------------------|
| 1 = Erythromycin (incl. Pediazole, ilosone) | 5 = Cotrimoxazole (bactrim/sepra) |
| 2 = Penicillin (Bicillin, Pfizerpen-AS, Wycillin) | 6 = Tetracycline/Doxycycline |
| 3 = Amoxicillin/Ampicillin/Augmentin/Ceclor/Cefixime | 7 = Other |
| 4 = Clarithromycin/azithromycin | 9 = Unknown |

Note: This Form has 2 Sides



*Maintain isolation until elimination of the organism is demonstrated by negative cultures of two samples obtained at least 24 hours apart after completion of antimicrobial therapy.

†Both nasal and pharyngeal swabs should be obtained for culture.

‡If equine diphtheria antitoxin is needed, contact your State Health Department. Before administration, patients should be tested for sensitivity to horse serum and, if necessary, desensitized. The recommended dosage and route of administration depend on the extent and duration of disease. Detailed recommendations can be obtained from the package insert and other publications.

§Antimicrobial therapy is not a substitute for antitoxin treatment. Intramuscular procaine penicillin G (25,000-50,000 units/[kg/d] for children and 1.2 million units/d for adults, in two divided doses) or parenteral erythromycin (40-50 mg/[kg/d], with a maximum of 2 g/d) has been recommended until the patient can swallow comfortably, at which point oral erythromycin in four divided doses or oral penicillin V (125-250 mg four times daily) may be substituted for a recommended total treatment period of 14 days.

¶Vaccination is required because clinical diphtheria does not necessarily confer immunity.

**Close contacts include household members and other persons with a history of direct contact with a case-patient (e.g. caretakers, relatives, or friends who regularly visit the home) as well as medical staff exposed to oral or respiratory secretions of a case-patient.

• A single dose of intramuscular benzathine penicillin G (600,000 units for persons < 6 years of age and 1.2 million units for persons ≥ 6 years of age) or a 7- to 10-day course of oral erythromycin (40mg/[kg/d] for children and 1 g/d for adults) has been recommended.

• Preventative measures may be extended to close contacts of carriers but should be considered a lower priority than control measures for contacts of each case.

¶¶Persons who continue to harbor the organism after treatment with either penicillin or erythromycin should receive an additional 10-day course of oral erythromycin and should submit samples for follow-up cultures.

¶¶ Refer to published recommendations for the schedule for routine administration of DTP.

Farizo KM, Strebel PM, Chen RT, et al. Fatal respiratory disease due to *Corynebacterium diphtheriae*: Case report and review of guidelines for management, investigation, and control. Clin Infect Dis 1993;16:59-68. Centers for Disease Control and Prevention. Manual for the Surveillance of Vaccine-Preventable Diseases 1996;2-8.

CDC Drug Service Diphtheria Antitoxin (DAT) Treatment And Adverse Effects

Patient ID	Name
Drug	Date of Request <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px;"> Month Day Year </div>

Diphtheria Antitoxin is currently not licensed in the United States. The National Immunization Program of the Centers for Disease Control and Prevention (CDC) is the national center for consultation of suspected diphtheria cases and is responsible for providing diphtheria antitoxin for therapy. CDC has received approval to distribute this product to physicians as an Investigational New Drug (IND) in accordance with requirements of the Food and Drug Administration (FDA). Under the provisions of our IND protocol we must obtain clinical information on each patient who has received DAT. Please complete and return this form at the time of hospital discharge for each patient receiving antitoxin. Please FAX form to: CDC Drug Service at (404) 639-3717 or mail form to: CDC Drug Service, Mailstop D09, Centers for Disease Control and Prevention, 1600 Clifton Road, Atlanta, Georgia 30333.

Was Sensitivity Testing Done Prior to Antitoxin Administration? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No	If Yes, at What Site? Other <div style="display: flex; justify-content: space-around;"> <input type="checkbox"/> Skin <input type="checkbox"/> Eye <input type="checkbox"/> Other </div>
What Dosage And Diluent?	Result

Antitoxin Given by Intravenous (IV) or Intramuscular (IM) Injection				
Dates DAT Given <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px;"> Month Day Year </div>	Time DAT Given <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px;"> </div>	Route <div style="display: flex; justify-content: space-around;"> <input type="checkbox"/> V = IV <input type="checkbox"/> M = IM </div>	Vials Given <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> </div>	Lot Number <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 20px; text-align: center;"> </div> </div>

(Excluding Reactions During Sensitivity Testing)				Give Details For All Adverse Effects, Including Location of Urticaria, Rash, Swelling, or Other Localized Adverse Effects.
Reaction	Y = Yes N = No	If Yes, How Long After DAT Given?	Duration of Reaction	Was Any Treatment Given For an Adverse Effect? If Yes, Describe. <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No Was Antitoxin Administration Stopped Due to an Adverse Effect? If Yes, Describe. <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No
General: Fever	<input type="checkbox"/>	_____	_____	
Chills	<input type="checkbox"/>	_____	_____	
Urticaria	<input type="checkbox"/>	_____	_____	
Swelling/Edema	<input type="checkbox"/>	_____	_____	
Anaphylaxis	<input type="checkbox"/>	_____	_____	
Serum Sickness	<input type="checkbox"/>	_____	_____	
Rash: Macular/Papular	<input type="checkbox"/>	_____	_____	
Vesicular	<input type="checkbox"/>	_____	_____	
Other	<input type="checkbox"/>	_____	_____	
Other Hypersensitivity	<input type="checkbox"/>	_____	_____	
Other Reaction	<input type="checkbox"/>	_____	_____	